August 31, 2016

Missouri State Board of Registration for the Healing Arts
PO Box 4
Jefferson City, MO 65102

RE: Proposed Assistant Physician Rules

Dear Missouri State Board of Registration for the Healing Arts:

The undersigned organizations are writing in reference to the Board of Registration for the Healing Arts (Board) proposed rules regulating Assistant Physician (AP) licensure. Our organizations are committed to working with the State of Missouri to help address physician workforce shortages in an attempt to provide adequate access to high quality health care for Missouri patients in rural and underserved areas.

The proposed rules make several changes to Missouri's licensure regulations to accommodate for the creation and regulation of the Assistant Physician. We remain concerned with the creation of a new type of health care provider, and would again like to comment on the ability of the Board to restrict licensure renewals to a finite number. We strongly believe that it was not the intent of the legislature to use APs as an alternative to full and unlimited physician licensure. We further believe that moving forward with allowing individuals who lack complete medical training to provide direct patient care under limited supervision places Missouri patients at an increased risk and threatens public health, safety and welfare.

We request that the Board limit the number of renewals to two in the final rule. Assistant Physician practice should provide medical school graduates who failed to match into a postgraduate residency program with a pathway toward full medical licensure and practice. This opportunity can offer APs time to develop their skills and medical knowledge as they seek a residency position. Limiting renewals to two years would also align with the law's requirement for an AP to pass the final portion of the licensure examination series after the second year. Upon the successful passage of the complete licensure examination series, followed by a minimum of one year of postgraduate training, APs will be eligible for full medical licensure in the State of Missouri.

During the initial comment period, several commenters supported limiting the number of renewals allowed for APs. It is our understanding that staff provided guidance that the Board was not authorized to limit the number of renewals based on the language of the statute. We believe this is contrary to the plain language in 334.036 which reads:

> "3. (1) For the purposes of this section, the licensure of assistant physicians shall take place within the processes established by the rules of the state board of registration for the healing arts. The board is authorized to establish rules under chapter 536 establishing licensure and renewal procedures, supervision, collaborative practice arrangements, fees, and addressing any such other matters as are necessary to protect the public and discipline the profession."

The language in the statute clearly provides the Board with the authority to establish rules for licensure and renewal, without mention of any limitation. When reading this in the context of the entire law, where the General Assembly did provide specific limitations on the specialty and location of AP practice and prescribing of controlled substances, it should be inferred that the General Assembly did not intend for the Board to be restricted in its authority to limit licensure renewal.

Had the Board included a limit on the number of renewal attempts for AP licensure in the proposed rule filed with the General Assembly, it would have been reviewed by the Joint Committee on Administrative Rules (JCAR). Under the authority granted in Missouri Revised Statutes Section 536.024, the JCAR could have provided guidance to the General Assembly if they believed there was an absence of statutory authority for the proposed rule or the proposed rule was in conflict with state law. The General Assembly could then have taken action to prevent the proposed rule from being implemented.

At this point, clarification of the Board's authority may be made in the form of a formal opinion by the Attorney General, per Missouri Revised Statutes Section 27.040.1. We are unaware of any attempt thus far by the Director of the Department of Insurance, Financial Institutions and Professional Registration to seek a formal opinion from the Attorney General on this issue. We believe it is imperative that the Board understand its full rights and responsibilities regarding its authority to regulate APs before moving forward to finalize the proposed rule. We request that the Attorney General review the content of Section 334.036.3(1). We further request that the Board delay finalizing the proposed rule until a formal opinion is made on the Board's authority to limit licensure renewal under this section.

Again, we appreciate the opportunity to comment and the willingness of the Board to consider our requests. Should you need any additional information, please feel free to contact Nicholas Schilligo, MS, Associate Vice President, AOA State Government Affairs, at nschilligo@osteopathic.org or (800) 621-1773, ext. 8185.

Sincerely,

American Academy of PAs
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American Osteopathic Association
A.T. Still University of Health Sciences Kirksville College of Osteopathic Medicine
Kansas City University of Medicine and Biosciences College of Osteopathic Medicine
Missouri Association of Osteopathic Physicians and Surgeons
St. Louis University School of Medicine
University of Missouri-Columbia, School of Medicine
University of Missouri-Kansas City, School of Medicine
Washington University School of Medicine in St. Louis

CC: The Honorable Chris Koster, Missouri Attorney General
John M. Huff, Director, Missouri Department of Insurance, Financial Institutions and Professional Registration

Coalition for Patients First

Protecting Patient Care & Preserving Health Equity

Overview

Students, interns, residents, and fully trained physicians all have a role in caring for the nation's patient populations. Licensed health care professionals should also have a clearly defined role in patient care that is consistent with their education, training and competencies.

The evolving health care system may require new types of professionals to play a patient-oriented role in health care. "Assistant Physicians" (AP) appear to be developing from medical school graduates who have been unable to enter a graduate medical education (GME) program, and not from a patient-driven need from the health care system. While there are apparently medical school graduates unable to pursue GME training, it is our opinion that this does not create a need for a new profession of partially trained and inadequately assessed graduate physicians.

The system that trains physicians gradually and cautiously introduces new physicians to the workforce after observed and direct assessment of their abilities in a health care environment, and testing in high stakes examinations. Those medical graduates who have not succeeded in this process should not be given a scope of practice similar to fully-licensed physicians who have completed all necessary and required training.

Position Statement

Standardized Licensure Requirements: Patient Safety, Transparency and Equity

The Coalition supports team-based care, which utilizes the expertise of a fully-trained and licensed physician, and is proven in its ability to deliver high-quality care to patients in need. In addition to passing a licensing examination series, which demonstrates competency, every state requires completion of at least one year of postgraduate residency training in order to be licensed as a physician. The Coalition believes that residency training provides medical school graduates with the necessary skills needed to deliver independent patient care and care delivered through the health care team.

Health care providers within the team should be utilized to the greatest extent of their education, training and competencies. Additionally, the Coalition believes that licensure eligibility should be standardized by profession and scope of practice. This is the only way that states can assure patient protection and transparency, and create an equitable system for licensing health care professionals.

Assistant/Associate Physicians: Incomplete Training, Limited Patient Protection

In 2014, Missouri enacted a law that created a new type of health care provider, the Assistant Physician. The Missouri law allows APs to provide primary care services to individuals in rural and/or underserved areas under the supervision of a licensed physician. While the law was enacted in 2014, the Missouri Board for the Healing Arts has not yet adopted final rules for the licensure of APs, and therefore none are currently in practice. The Board sent draft rules to the Governor's Office for review and approval, and Governor Jay Nixon approved the proposal. The final rules have now been published for a 30-day open comment period, ending August 31, 2016.

During the 2015 legislative session, Kansas and Arkansas proposed similar bills. These bills were amended to limit renewals, require continuous direct supervision and ensure patient safety. During the 2016 state legislation cycle, bills were introduced in Washington State and Virginia. These bills are very similar to the Missouri law, and would create an "Associate Physician" license, allowing individuals who lack complete medical training to provide this care to patients under limited supervision. Though the terminology varies by state, the "Assistant" and "Associate" Physician positions are similar in concept.

The Coalition remains concerned with the Missouri law and similar proposals in other states. Allowing medical school graduates without complete medical training to provide independent patient care under limited supervision may jeopardize patient safety. States must also understand that this is a dangerous precedent that establishes an inappropriate standard for the delivery of health care to patients in rural and/or underserved areas.

Additionally, promoting primary care as a fallback or an alternative to a student's desired specialty is inappropriate. This devalues the important and necessary care that primary care physicians provide to patients

as a first line defense in protecting patient well-being and advancing population health. Individuals who fail to match into their desired medical specialty will not necessarily make a good primary care physician, which is another example of why these proposals will prevent states from meeting their overall goal of increasing the delivery of high quality primary care to patients in rural and underserved areas.

Key Concerns and Talking Points

1. Medical school graduates are not prepared or trained to provide independent care to patients. Medical schools strive to graduate students who are prepared to enter the next phase of their professional career pathway, residency training. They require continuous direct supervision, as provided through the postgraduate residency training experience. Their role in delivering care expands, as they continue to develop the skills, knowledge and competencies required to deliver high-quality, comprehensive patient care.

    a. Medical school provides exposure and fully supervised experiences, ensuring the safety of patients and that patient care is not delivered without appropriate and safety-driven oversight. The assessment of independent practice is not part of clinical clerkships in the 3rd and 4th years of training.

2. Residency training is critical and required to become a licensed physician to practice independently. These proposals, while well meaning, disregard the decades of evidence and experience behind established GME programs in the US.

    a. Accredited residency programs are highly structured to provide a well-rounded and rigorous clinical and educational experience for medical school graduates.
    b. Traditional residency programs are based in environments that have clinical education as a core mission, with residents providing care under the supervision of physician educators. Residents are evaluated based on standardized approaches that examine the residents' knowledge base, clinical skills and professionalism, while also identifying those in need of more training. Based on these assessments, residents are afforded progressively greater autonomy.
    c. Diagnostic analytic thought patterns are developed by a physician and individual practice patterns are established during this phase of the medical education experience. This is the aspect of training that provides a professional with the competency for independent thought and practice.
    d. In the midst of training, it is inappropriate to confer a title implying training is complete. Physicians are trained for independent practice and any legislative intervention that subverts the end product of medical training is harmful to both patients and to the larger health care system.

3. These proposals create a two-tiered physician system whereby some patients have access to fully-trained and licensed DOs/MDs whose abilities do not require supervision, and others would receive care from those who complete medical school, but lack patient care knowledge and skills because they have not completed residency training. Patients in rural and underserved areas, who are already at a geographic and often economic disadvantage, deserve the same quality of care as those who live in prosperous areas of the state.

    a. This includes receiving care from licensed health professionals who have completed the necessary education and training.
    b. Health care consumers also deserve transparency from the health professionals who are providing their care. The AP title has the potential to confuse patients, health systems, payers and other providers.

4. These attempts run counter to efforts to raise the bar for health care providers, by maintaining/increasing standards for licensure and supporting competency demonstration requirements that adequately protect patients. Lowering the bar for who can provide care to patients degrades these ongoing efforts and creates inequity in the licensing requirements for health care providers licensed to provide the same health care services. In doing so, states will erode the trust of the patient and the public, a critical factor in the successful delivery of services in the patient-centered model of care.

5. Last year, over 95% of US medical students secured a residency training position. The numbers of unmatched medical school graduates from LCME or AOA accredited colleges are too small to make noticeable progress toward addressing workforce shortages.

    a. These proposals fail to take into account that certain individuals fail to match into a training program because of their specialty choice.
    b. Primary care residency slots remain available for qualified medical school graduates with an interest in practicing in these specialties.

6. If the goal is to address primary care workforce shortages, while ensuring access to optimal patient care, states would be wise to take a different approach. States should instead focus on increasing residency funding to create new and expand existing primary care training programs. States should also provide support for programs that encourage medical school graduates to pursue primary care specialties, particularly in rural and underserved areas. Programs like health provider loan repayment/forgiveness and Medicaid payment parity for primary care services are examples of proven strategies. States should consider optimizing state statutes and rules to ensure that all health professionals are practicing to the top of their education and experience.

    a. This is the best way to create fully-trained and licensed physicians equipped to handle the complex primary care needs of patients, and address workforce shortages across all health care provider types in rural and underserved areas.
    b. New models of care delivery like telemedicine, Accountable Care Organizations and Patient Centered Medical Homes are also effective ways to maximize the impact of the existing health care workforce. States should focus on providing appropriate payment for team-based care provided in these delivery models.

Member Organizations

American Academy of PAs
American Academy of Pediatrics
American Association of Colleges of Osteopathic Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
Association of American Medical Colleges
American Medical Association
American Osteopathic Association